SENATE BILL No. 434

DIGEST OF INTRODUCED BILL

Citations Affected: None (noncode).

Synopsis: Case mix reimbursement for nursing homes. Requires the office of the secretary of family and social services to make various amendments to the administrative rule regarding the Medicaid case mix reimbursement system for nursing homes. Requires the office of Medicaid policy and planning to apply to the federal Health Care Financing Administration for a Medicaid state plan amendment to implement certain rule changes. Prohibits the office of the secretary of family and social services from repealing or amending certain administrative rules without statutory authority.

Effective: Upon passage.

Miller

January 18, 2001, read first time and referred to Committee on Finance.

Introduced

First Regular Session 112th General Assembly (2001)

PRINTING CODE. Amendments: Whenever an existing statute (or a section of the Indiana Constitution) is being amended, the text of the existing provision will appear in this style type, additions will appear in **this style type**, and deletions will appear in ~~this style type.~~

Additions: Whenever a new statutory provision is being enacted (or a new constitutional provision adopted), the text of the new provision will appear in **this style type**. Also, the word **NEW** will appear in that style type in the introductory clause of each SECTION that adds a new provision to the Indiana Code or the Indiana Constitution.

Conflict reconciliation: Text in a statute in *this style type* or ~~*this style type*~~ reconciles conflicts between statutes enacted by the 2000 General Assembly.

SENATE BILL No. 434

A BILL FOR AN ACT concerning Medicaid.

Be it enacted by the General Assembly of the State of Indiana:

SECTION 1. [EFFECTIVE UPON PASSAGE] **(a) The definitions in 405 IAC 1-14.6, as in effect on January 1, 2001, apply throughout this SECTION.**

(b) Not later than January 1, 2002, the office of the secretary of family and social services established by IC 12-8-1-1 shall adopt rules under IC 4-22-2 to make the following Medicaid reimbursement changes to 405 IAC 1-14.6:

(1) Physical therapy, speech therapy, occupational therapy, and respiratory therapy services shall be removed from the direct care rate component and calculated in a new rate component called "therapy". A profit add-on payment may not be added to the calculation of the therapy rate component, and there is no limitation on the amount of the therapy rate component in the rate calculation. The therapy rate component shall be calculated as follows:

STEP ONE: Divide the Medicaid revenue for each therapy service by the total revenue for each therapy service.

STEP TWO: Multiply the amounts determined under

STEP ONE for each therapy service by the total cost of each therapy service.

STEP THREE: Add the amounts determined under STEP TWO.

STEP FOUR: Divide the total amount determined under STEP THREE by total Medicaid days.

STEP FIVE: Add the amount determined under STEP FOUR to the rate calculated for the provider.

(2) A provider's indirect care rate component shall be limited to the product of:

(A) the average allowable cost of the median patient day for indirect care costs; multiplied by

(B) one hundred ten percent (110%).

(3) A provider's administrative rate component shall be limited to the product of:

(A) the average allowable cost of the median patient day for administrative costs; multiplied by

(B) one hundred five percent (105%).

(4) Expenses for repairs and maintenance shall be removed from the capital component and calculated as part of the indirect care component.

(5) The owner and management compensation annual limitations contained in 405 IAC 1-14.6-18, as in effect on January 1, 2001, shall be increased by ten percent (10%) beginning with the July 1, 2000, limitation.

(6) A provider's direct care rate component shall be limited to the product of:

(A) the normalized average allowable cost of the median patient day for direct care costs; multiplied by

(B) the facility average case mix index for Medicaid residents; multiplied by

(C) one hundred twenty percent (120%).

(7) A provider's capital rate component shall be limited to the product of:

(A) the average allowable cost of the median patient day for capital costs; multiplied by

(B) ninety percent (90%).

(8) The profit add-on for the capital component is equal to sixty percent (60%) of the difference (if greater than zero (0)) of:

(A) the average allowable cost of the median patient day multiplied by ninety percent (90%); minus

(B) a provider's allowable per patient day cost.

(9) Allowable costs per patient day for capital related costs shall be computed based upon an occupancy level equal to the greater of:

(A) eighty-five percent (85%); or

(B) the provider's actual occupancy from the most recently completed historical period.

(10) Expenses for property taxes shall be removed from the capital rate component and calculated in a new rate component called "property taxes". A profit add-on payment may not be added to the calculation of the property taxes rate component, and there is no limitation on the amount of the property taxes rate component in the rate calculation.

(11) The state's rate setting contractor shall calculate medians and provider rates as follows:

(A) "Most recent completed year", for purposes of 405 IAC 1-14.6-7(a), means the most recently completed fiscal year of the provider. The term does not mean the most recent completed cost reports on file.

(B) The state's rate setting contractor shall calculate the median for each rate component each quarter using all cost reports received by the state or the state's rate setting contractor within one hundred fifty (150) days after each provider's fiscal year end. The rate setting contractor shall request any additional information from a provider not later than twenty-one (21) days after the cost report is received by the rate setting contractor, and the rate setting contractor shall include in the medians and the provider's rate calculation all responses received within one hundred ninety (190) days after the provider's fiscal year end. If a draft audit report has been issued for a provider within one hundred fifty (150) days after the provider's fiscal year end, the rate setting contractor may request additional information relative to that draft audit report. If the draft audit report is issued later than one hundred fifty (150) days after the provider's fiscal year end, the rate setting contractor may not request additional information relative to that draft audit report for that rate review.

(12) The cost of professional liability insurance shall be separated from the administrative rate component and calculated in a new rate component called "professional liability insurance". A profit add-on payment may not be

added to the calculation of the professional liability insurance rate component, and there is no limitation on the amount of the professional liability insurance rate component in the rate calculation. Each provider shall submit current liability insurance premium statements and supporting documentation to the state's rate setting contractor. The professional liability insurance component in the provider's rate must be equal to the liability insurance expense from the current liability premium statements and supporting documentation divided by the total patient days from the provider's most recently filed cost report. The rate adjustment is effective on the first day of the month if the effective date of the policy is on or after the first day of the same month but before the sixteenth day of the same month. If the effective date of the policy is after the fifteenth day of the month but on or before the last day of the month, the rate adjustment shall be effective on the first day of the following month. For the calculation of reimbursement rates effective after June 30, 2003, the cost of professional liability insurance must be included in the administrative rate component, subject to the profit add-on payment and the limitation on the administrative rate component.

(13) The reimbursement rate for providers having a ventilator patient shall be increased to compensate for the change to the reimbursement rate required by subdivision (1).

(14) The reimbursement rate for each provider shall be increased to compensate each provider for increased training and ongoing in-service related to Alzheimer's disease and related senile dementia.

(15) The reimbursement rate must be equal to the sum of the following components:

(A) Direct care.

(B) Indirect care.

(C) Administrative.

(D) Capital.

(E) Therapy.

(F) Property taxes.

(G) Liability insurance.

(16) The state shall use Resource Utilization Group 5.12, 34 grouper, to determine each resident's case mix index (CMI) that is used to calculate the facility average CMI for all residents and to determine the facility average CMI for

Medicaid residents. The CMIs used to calculate the facility average CMI for all residents and to determine the facility average CMI for Medicaid residents shall be as follows:

RUG-III Group	CMI
RAD	2.02
RAC	1.69
RAB	1.50
RAA	1.24
SE3	2.69
SE2	2.23
SE1	1.85
SSC	1.75
SSB	1.60
SSA	1.51
CC2	1.33
CC1	1.27
CB2	1.14
CB1	1.07
CA2	0.95
CA1	0.87
IB2	0.93
IB1	0.82
IA2	0.68
IA1	0.62
BB2	0.89
BB1	0.77
BA2	0.67
BA1	0.54
PE2	1.06
PE1	0.96
PD2	0.97
PD1	0.87
PC2	0.83
PC1	0.76
PB2	0.73
PB1	0.66
PA2	0.56
PA1	0.50

(17) A phase-in period is not allowed for implementation of the new reimbursement rates required by this SECTION.

(c) This SECTION expires July 1, 2003.

SECTION 2. [EFFECTIVE UPON PASSAGE] **(a) Before July 1,**

2001, the office of the secretary of family and social services established by IC 12-8-1-1 shall adopt emergency rules in the same manner that emergency rules are adopted under IC 4-22-2-37.1 to implement SECTION 1 of this act.

(b) An emergency rule adopted under subsection (a):

(1) is effective on July 1, 2001 (unless final rules to take effect on or before July 1, 2001, are adopted earlier under SECTION 1 of this act); and

(2) expires on the effective date of rules adopted under SECTION 1 of this act.

(c) This SECTION expires July 1, 2003.

SECTION 3. [EFFECTIVE UPON PASSAGE] **(a) Not later than September 30, 2001, the office of Medicaid policy and planning established by IC 12-15-1-1 shall submit a state plan amendment to the federal Health Care Financing Administration to implement this act. However, approval of the state plan amendment by the federal Health Care Financing Administration is not required for the office to pay the modified reimbursement rates required by this act.**

(b) This SECTION expires July 1, 2003.

SECTION 4. [EFFECTIVE UPON PASSAGE] **(a) The office of the secretary of family and social services established by IC 12-8-1-1 shall recalculate, publish, and pay Medicaid reimbursement rates as modified by this act.**

(b) The state's rate setting contractor shall calculate and notify providers of their rates under this act not later than September 1, 2001, using the most recently completed cost reports on file as of July 1, 2001.

(c) This SECTION expires July 1, 2003.

SECTION 5. [EFFECTIVE UPON PASSAGE] **(a) The office of the secretary of family and social services established by IC 12-8-1-1 shall not do any of the following:**

(1) Repeal 405 IAC 1-14.6.

(2) Amend 405 IAC 1-14.6 in any manner that reduces reimbursement for nursing facilities, except as required by SECTION 1(b)(1) of this act, or adopt any other rule under IC 4-22-2 that reduces reimbursement for nursing facilities.

(3) Repeal or amend a rule adopted under this act without statutory authority for the repeal or amendment.

(b) This SECTION expires July 1, 2003.

SECTION 6. **An emergency is declared for this act.**